

Pediatrics & Parents

The newsletter for people who care for children

Richard J. Sagall, MD, Editor

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Early Food Preferences

It's never too early to start helping your children like healthy foods. According to Julie Mennella, PhD, of the Monell Chemical Senses Research Institute of Philadelphia, flavors found in the mother's diet are found in amniotic fluid and breastmilk. She believes that women who eat a healthy diet while pregnant and breastfeeding give their children a liking for these foods.

In her study, the children of pregnant women who consumed large quantities of carrot juice or raw fruits like carrots and fruits more than children whose mothers didn't drink the carrot juice or eat raw fruits. Other studies have shown similar results for green beans, aniseed-flavored fluids and garlic.

These studies reinforce the influence the early maternal diet has on children.

www.News-Medical.net, 12/07

When Dogs Bite Children

When dogs bite children it's because they feel threatened. Children under six years old are more likely to be bitten when the dogs felt their food or toys were threatened. For older children, bites occur most often when the dogs believed their territory was being threatened.

These are results of a study of 111 dog bites by 103 dogs referred to a veterinary behavioral clinic at the University of Pennsylvania over a four-year period. Twenty percent of the dogs had never bitten before and two-thirds had not previously bitten a child. Ninety-three percent of the dogs had been neutered and 66% had been to obedience training classes.

Three-quarters of the dogs were anxious when left alone by their owners or exposed to loud noises. Half the dogs had medical conditions, mostly bone or skin problems. Dogs that are fearful have a tendency to bite when facing a perceived threat. Since young children tend to be noisy and move unpredictably, anxious dogs are prone to be frightened by these actions – and respond by biting.

According to the Centers for Disease Control and Prevention (CDC), 42% of all dog-bite admissions are children under the age of 14.

Injury Prevention, 10/07

2007 Top Ten Children's Hospitals

U.S. News and World Report recently issued its 18th annual Best Children's Hospitals list, where it ranks children's hospitals throughout the country. In the past, the list consisted only of hospitals based on their reputations, not on their ability to treat children. This year, the list includes hospitals renown for their reputation, ability to treat and release patients, and other care-related factors. For the first time, the publication selected three difficult medical procedures that are a measurement of the medical staff's skill (heart repair, brain surgery and bone marrow transplant), then sent 122 hospitals an email survey that asked them how many of each of the three procedures they performed and how successful they were.

For the rankings criterion, 200 pediatricians, adolescent medicine specialists and neonatologists were randomly selected from the American Medical Association's database of 850,000 physicians and asked to name five hospitals – without regard to location or cost – where they think a child in need of the highest

level of care would receive it (they were not allowed to name the hospital where they worked).

Below are the results for the Top 10 Children's Hospitals. Additional methodology information, as well as lists for pediatric specialties, can be found on *U.S. News and World Report's* website.

1. Children's Hospital of Philadelphia
2. Children's Hospital Boston
3. Johns Hopkins Hospital, Baltimore
4. Children's Hospital, Denver
5. Rainbow Babies and Children's Hospital, Cleveland
6. Texas Children's Hospital, Houston
7. Cincinnati Children's Hospital Medical Center
8. New York-Presbyterian Univ. Hosp. of Columbia and Cornell
9. Children's Hospital and Regional Medical Center, Seattle
10. Lucile Packard Children's Hospital, Palo Alto, CA

Loud Toys and Hearing Loss

Toys are getting louder – and damaging children's hearing. According to the Consumer Products Safety Commission (CPSC), "Electronics are among the fastest-growing segment of the toy market and are being marketed to younger and younger children." The CPSC warns that lists of toy-related dangers rarely include hearing loss from loud toys and electronics.

"It's up to adults to safeguard our children and protect them from dangers that we can easily avoid, including lead, choke hazards – and hearing damage from loud toys or playing video games and music too loud, too long," says Norma Anderson, PhD, president of the American Speech-Language-Hearing Association (ASHA). Once hearing loss occurs, the ears don't recover.

The ASHA offers the following guidelines:

- If you must raise your voice to be heard, the noise is loud enough to damage hearing.
- When evaluating toys for small children, remember that their arms are short and they tend to hold toys close to their faces, making noises even louder.
- If you can hear music from someone else's earphones three feet away, it's too loud.
- Give your ears a break from continuous listening.
- Set volume limiters before allowing children to use electronic items.

- Upgrade headphones so that they isolate music from background noise. Lower volumes can then be used.
- www.listentoyourbuds.org is a fun website created by hearing experts and educators with video games for kids, and information for teachers and parents to learn about hearing safety.

Here are some tips for recognizing a child with a hearing loss:

- Frequently misunderstands what is said and wants things repeated
- Difficulty in following verbal instructions
- Turns up the volume of the TV, radio, or stereo
- Difficulty listening or paying attention when there is noise in the background
- Trouble identifying and/or localizing sounds
- Reading, spelling, and other academic problems
- Feelings of isolation, exclusion, annoyance, embarrassment, confusion, and helplessness
- Behavior problems
- Pulling or scratching at ears
- A history of three or more ear infections

A parent who suspects her child has a hearing loss should discuss her concern with the child's doctor. A hearing test (audiogram) is easy, quick, and painless. Detecting an early hearing loss may prevent further damage.

The Crisis of Childhood Obesity: What You Can Do

By Tiffany C. Rush-Wilson, PhD

Childhood and adolescent obesity is a problem that impacts members of all races and socioeconomic groups. There are many mental health, psychosocial, and medical consequences that must be made clear to clinicians, parents, and children who are living with obesity. A definition of childhood obesity, signs and symptoms, medication interventions, and future directions of treatment will be discussed in this article.

During the past ten years, obesity in the United States has doubled, and currently one in six children is obese. Due largely to this health crisis, we now have a generation of children with a projected life expectancy that is shorter than that of their parents. In the last two decades, the number of children and teens with obesity (ages 2–18) increased nearly 300%, with the number of overweight African-American and Hispanic/Latino children increasing dramatically and disproportionately (nearly one-fourth of children from these groups are overweight). These numbers are of epidemic proportions across racial and ethnic groups in this country.

These disconcerting statistics have inspired a media influx of information about eating disorders (including anorexia nervosa, bulimia nervosa, and binge eating), healthy choices in food selection, and exercise. Children, parents, and clinicians, as consumers of food and the media, may have difficulty determining what data to accept and what to further investigate.

Contemporary reports highlight traditional approaches to reducing obesity, including diet and exercise, calorie reduction, and the infusion of fresh fruits and vegetables into children's lives. Criticisms of the reduction and elimination of physical education activities in school curricula, as well as the accessibility of sugary and fattening snacks have also been evident, and the media continues to provide balanced accounts of body size. Controversial treatments – such as using medications intended for purposes other than weight loss, and exercise programs that minimize the importance of cardiovascular activity in favor of strength training – have been gaining attention. Such contradictory information can make decision making difficult.

What is obesity? Simply put, obesity is a condition in which a person's weight is more than 20% greater than

is recommended for his or her height and age. Believe it or not, there is no official diagnosis mental health clinicians use to determine the potentially complicated psychological process of overweight in children.

Some clinicians, however, use the Body Mass Index (BMI), a formula that can be used to calculate obesity. To calculate your BMI (using English standard measurements), divide your weight in pounds by your height in inches. Use that number and divide it once again by height in inches and then multiply it by 703. A result that is smaller than 18.5 indicates that a person is underweight. A healthy weight range is between BMI scores of 18.5 and 24.9, overweight scores are 25.0–29.9, and obesity scores begin at 30.0.

There can be social consequences for children who are overweight. Obese children may endure teasing, difficulties with physical activities, and self-esteem problems related to negative media images. Psychiatric literature about disordered eating has been available in the media and academia for many years. A greater amount of information is now available about how to diagnose, treat, and support children who are overweight.

There is no single cause of obesity. The etiology, or cause, can be complex. Some children's obesity can be traced to medical conditions, chemical sensitivity, or even adrenal gland function. Other causes may be related to psychological, family, and cultural factors. Modern society places a great deal of emphasis on having an "ideal" body. Marketing ads geared toward children and young adults promote the idea that having a perfect body is associated with having a great life, affluence, an active social life, and many other benefits. Just look at the next toy or music ad and look for the chubby children. They're not there. Children may compare themselves to these images and develop an eating-disordered mentality.

There are three primary categories of eating disorders. Anorexia nervosa is a rare syndrome that affects one-half to one percent of the U.S. population of adolescent girls. Symptoms include dramatic weight loss, restrictive eating patterns, and psychological distress. The disorder has been well researched for more than a century.

Bulimia nervosa, or the binge-purge syndrome, is more common than anorexia nervosa and affects one to three percent of the adolescent female population in the United States.

Although the American Psychiatric Association does not yet officially list Binge Eating Disorder (BED) as an eating disorder, ongoing diagnostic supports this syndrome. People who meet the proposed requirements for BED consume more food and calories than the average person at a sitting and feel guilt about the consumption as well as a lack of control over their eating, but they do not use unhealthy means to get rid of the food. Of the three eating disorders, BED is the most common. Research has estimated that more than one-half to four percent of the population may have this syndrome. Other estimates are higher. Overweight children, who may feel a lack of control over their eating and eat beyond the point of satiety, thereby consuming more calories at a single sitting than the average adult, can suffer from this psychological condition. This overeating is a serious concern. Excessive weight gain can lead to problems with obesity, premature puberty, diabetes, and other medical complications.

While certainly increasing in prevalence, childhood obesity is not new. As a clinician who treats eating disorders, I have seen serious cases of obesity in children, with two being particularly striking. In the 1970s, there were two children in my second-grade class who had severe problems with obesity. Both of these clients were young girls; one was six years old and the other was twelve. From these two cases, I learned two important obesity factors. First, the “clean your plate” rule, a well-meaning standard in both of these girls’ lives, can be counterproductive. A six-year-old child has different nutritional needs than an adult. This child, at such a young age, weighed 10 pounds more than is recommended for a 5’2” adult woman. The 12 year old was morbidly obese and used food as a method to self soothe. Her eating practice was ultimately seen as an issue of neglect by social services, and her extreme overweight ultimately became the opening for outside help and support. It was her proverbial cry for help.

So what can you do to help ensure your child is a healthy weight? Here are a few suggestions to get you started.

- If you are concerned about your child’s weight, make an appointment with her physician to rule out any physical causes. Discuss your concerns. After a physical examination, your child’s physician will be able to make a recommendation about how to proceed. Do not encourage your child to begin a

weight modification plan without first consulting a physician.

- Talk to your child about healthy food choices. Help her distinguish between unhealthy popular foods and healthy choices.
- Learn about organic foods. While they are usually more expensive than conventional foods, having fewer chemicals in your child’s diet can be beneficial.
- Plan out menus together and encourage your child to participate in meal preparation.
- Convenience foods are a necessity in the lives of many busy families. If it is not feasible to eliminate these from your child’s diet, consider incorporating fresh fruits and vegetables and salads into mealtime.
- Model healthy eating and exercise behaviors. Children learn from watching the actions of the influential adults in their lives.
- Talk to your child about the reasons we eat – to nourish ourselves – and help her have an awareness of eating for non-hunger reasons.
- Discuss emotional eating with your child. Talk about ways to identify and express emotions that are not related to food.
- Ensure that your child has a trustworthy adult confidant. Often this person is a parent, trusted relative, teacher, someone affiliated with a religious congregation, or the parent of a close friend. Access to a responsible, trustworthy adult will be a tremendous asset to your child’s emotional well being.
- Parents, move your body! Dance with your child, go for walks, and engage in physical activities as a family. Unfortunately children and adolescents have less access to physical education and recess than they did a decade ago. The physical activity that they get at home may be a major component of their overall exercise.
- Encourage your child to join extracurricular activities such as sports, which may help improve her self-esteem and physical health.
- Limit the amount of time your child engages in sedentary activities. While television viewing, video

games, Internet usage, and other similar activities can be fun and mentally engaging, they do not promote much physical movement.

- Consider doing a charity walk/ run together. These events often have a children's walk/ run event.

Dr. Rush-Wilson conducted her graduate training at John Carroll University (MA) and at the University of Akron (PhD). Her master's independent study was on eating disorders. Her doctoral dissertation was a qualitative study on eating disorders among African-American women. The research generated a theory of why women in this group develop and suffer from these disorders.

Diaper Rash Myths

Rare is the baby that doesn't get a diaper rash now and then. There are two common types of diaper rash, technically called diaper dermatitis: simple (irritant) and candida (yeast).

When feces and fecal enzymes, combined with urine, are in contact with the baby's skin for a long time, the skin becomes inflamed, resulting in irritant diaper dermatitis. The rash usually appears on the baby's buttocks, but may extend onto the thighs, waist, and even the stomach. Skin folds are generally spared. The rash looks red and shiny.

Yeast dermatitis is caused by *Candida albicans*. Unlike the rash of irritant dermatitis, yeast dermatitis usually begins in the skin folds of the thighs and in the diaper area. Then it spreads to rest of the bottom. It has a deep red and shiny appearance. There may be "satellite" lesions on the legs or stomach. The baby may also have thrush, an oral yeast infection.

According to Mary K. Spraker, MD, of the medical college at Emory University, "Over the years, there have been considerable improvements in the design of modern disposable diapers and, as a result, severe diaper rash is not as common as it once was. Numerous studies have shown that infants who wear today's disposable diapers get fewer diaper rashes than infants who wear traditional cloth diapers."

For irritant diaper dermatitis, the best treatment is prevention. In severe or chronic cases, barrier treatments such as Lassar's Paste or Triple Paste work well. For yeast diaper dermatitis, Dr. Spraker recommends Vusion, a prescription antifungal recently approved by the FDA. Prior to this product, many babies were treated with adult-strength antifungals.

At a recent meeting of the American Academy of Dermatology, Dr. Spraker described some common diaper rash myths.

Change the Diaper Each Time the Baby Urinates

The normal newborn urinates 20 or more times each day. It's neither practical nor necessary to change the diaper after each urination. Not only would doing so take a lot of time, but it would become very expensive. Unless their is stool mixed with the urine, it's only necessary to change the diaper six to eight times per day. That's also how often six-month old infants urinate.

Wash the Baby at Each Diaper Change

Dr. Spraker said, "Not necessary, because urine isn't irritative." Only if there's stool mixed with the urine will it irritate the skin. Washing a baby's diaper area too often can irritate the skin and increase the chances of irritation. "Aggressive cleaning with soapy water, for example, would be even more deleterious," said Dr. Spraker.

Keep the Baby Dry

Overly aggressive efforts to keep the baby's bottom dry may do more harm than good. Using a hair dryer to blow dry the skin may cause skin chafing, giving it a "wind burn" and making diaper dermatitis more likely. Baby powder should be avoided. It has little absorptive abilities. And if inhaled, it can irritate the baby's lungs, causing a pneumonitis.

Wipes Will Irritate the Baby's Skin

Only if they contain alcohol. Most wipes on the market now are designed to be "skin neutral." They may not be very moisturizing, but are not very drying either. Dr. Spraker believes they are fine to use.

(Dr. Spraker has been a consultant for Kimberly-Clark, a maker of disposable diapers, and Barrier Therapeutics, maker of Vusion.)

Pediatrics News, 4/07

Medication Expenses

Top five medicines for children ages newborns to 17 year olds by expenditure (2004)

Medicine	Disease	Expenditures (millions)
Singular	Asthma	\$680
Concerta	ADHD	\$49
Strattera	ADHD	\$49
Zyrtec	Allergies	\$42
Adderall	ADHD	\$41

Hospitals & Health Networks, 10/07



Children in Hospitals

By John E. Monaco, MD

The Many Faces of RSV

Dominic was seven weeks old when his mother recently brought him to the ER one Sunday morning. She brought him because she was concerned about his breathing. He had been slightly congested for several days, but on this particular morning it was his breathing pattern that worried her. As she later described it, he would be breathing fine and then “just sort of stop” for a few seconds.

The ER doctor tested the child for RSV, a respiratory virus prevalent across the country this time of year, and the test came back positive. Dominic was indeed infected with RSV – respiratory syncytial virus. Because he had minimal congestion, was not really wheezing or breathing rapidly, and did not exhibit a need for supplemental oxygen, he was sent home with instructions to return if he worsened.

As the day progressed, Dominic’s mother became increasingly alarmed. Again, it was his breathing pattern that disturbed her. His respiratory “pauses” were increasing in frequency and duration, and there were times when she actually had to shake him in order to get him breathing normally again. Finally when one of these episodes lasted particularly long, Dominic actually began to turn blue. It was at this point that she called 911 and instructed EMS to bring Dominic to our hospital.

Dominic exhibited one of the classic presentations of an infection with RSV, but not one that is commonly seen. In infants, RSV can not only infect the entire respiratory tree, but it can sometimes affect the respiratory centers in the central nervous system resulting in apnea, or cessation of breathing. Sometimes this is the first sign of infection with this seasonal respiratory virus, before the other more commonly recognized signs and symptoms like fever, congestion, wheezing and rapid breathing set in.

We first treated Dominic with supplemental oxygen and this seemed to help considerably. Soon, however, his apnea recurred. As the staff and family hovered

at his bedside, we watched Dominic exhibit the very classic pattern of apnea associated with RSV. At first he would be breathing comfortably and normally when suddenly his chest would stop moving. The respiratory rate monitor would at the same moment show a flat line. After 10 or 15 seconds his heart rate would begin to slowly decelerate.

After a few more seconds, his oxygen saturation would begin to drop, but usually at this point he would sort of shake himself out of it and start to breathe regularly. If he did not come out of the “spell” on his own, the nurses would shake him gently and he would begin to breath normally again. After several minutes the cycle repeated itself again.

We tried other measures – aerosol breathing treatments with albuterol, systemic steroids and even caffeine – that didn’t work and eventually had to intubate Dominic and place him on a ventilator. Once we were in control of his respiratory effort, he did beautifully. When the apnea associated with RSV becomes severe enough to require mechanical ventilation, the approach then is to simply let some time go by, and try to wean the child from the ventilator when the peak of the disease seems to have passed. At this point, normal respiratory pattern returns.

Most everyone is familiar with the usual signs of an infection with RSV. It is so prevalent in the fall, winter and early spring in most of the United States that many parents and caregivers alike become complacent due to the repetitiveness of the respiratory signs of infection in the pediatric population. Every once in a while, however, there is an infant that presents with apnea. Initially, the signs can be subtle, but if left unchecked the results can be disastrous. Infants under two or three months of age are at particular risk and should be monitored especially closely during the RSV season.

John E. Monaco, MD, is board certified in both Pediatrics and Pediatric Critical Care. His new book, [Moondance to Eternity](#), is now available. He lives and works in Tampa, Florida. He welcomes your comments, suggestions, and thoughts on his observations.

Night Terror

By Lynn Masters-Zaleski

There is nothing more comforting than seeing your child safely tucked in bed sleeping peacefully, but then, moments later, nothing more frightening than witnessing the blank stare of a child who does not recognize you. Night terror, also known as sleep terror, is just this type of sleep disturbance that can terrify parents enough to contact their pediatrician at once. According to one study, night terror afflicts approximately 6.2% of children between the ages of six to twelve years and is even more common in young children.

Symptoms can surface as early as 18 months and are highly prevalent in very young children, with a marked decrease toward adolescence. "Night terrors usually occur about two hours after a child falls asleep, when the first cycle of deep sleep has suddenly come to an end and light waking has not fully occurred," says Dr. Joshua D. Sparrow, pediatric psychiatrist and Harvard Medical School professor.

A blood curdling scream may signal the onset of night terror with a host of symptoms following that clearly define the disorder: thrashing, rapid heartbeat, profuse perspiring, shouting, babbling, agitation, wild running, a blank stare, tense facial features and an expression resembling one possessed.

Rest assured that your child is not having a seizure and does not have a medical condition. Night terrors do occur in perfectly healthy children. Often they are accompanied by sleepwalking and talking and can last as long as 15 minutes.

While anxiety may be at the base of your child's night terror, there is much you can do to help prevent anxiety, and therefore night terrors. Create leisurely time whenever possible to engage in fun activities such as swimming and splashing in a pool. Indoors or outdoors, whether pushing a kickboard or bouncing a beach ball, spend time together and have fun. Water is purifying and cleansing with restorative calming properties. It will do both of you good.

Night terror episodes may occur when children are overtired. Try giving him a nap or getting him to bed earlier with a consistent time schedule at nighttime for sleep. According to Dr. Sparrow, sleep expert and author of *Sleep The Brazelton Way*, "The best protection against night terrors may actually be adequate sleep at naptime and at night."

Your child may be going through difficult times, so try putting time aside to find out if all is going well in his

life. You may want to mention to the school psychologist and teacher that your child is experiencing night terror so that they too can keep a watchful eye on your child in the classroom and on the playground.

Dr. Sparrow cautions parents not to grill your child about the night terror afterward. Children don't remember.

Dr. Sparrow offers this expert advice:

- Don't try to awaken the child.
- Leave him in his crib, or if he has climbed out, lead him back to bed if he will let you.
- Be sure he is safe.
- Don't talk about it a lot during the day. He cannot control himself, and dwelling on these episodes will endanger his feelings about himself.
- Reduce stresses on him during the day, as he may be going through a vulnerable time.

A dose of humor can have far reaching affects and is one of the best ways to reduce stress. Try reading your child a funny story or two where both of you can laugh. If he is very young, give him a cuddly animal to hold onto, or a favorite blanket that he can hug. A talisman such as a Chinese foo dog may work better for an older child. Place it where he can see it knowing that it is guarding and protecting him all night long, or perhaps hang a Native-American dream catcher in his room. Sometimes just being reassured can make all the difference.

Lynn Masters-Zaleski, MA, earned her masters in education from Iona College. Her principal interest is tension-discharge disorder, impulse ridden personality. She is a freelance writer. Her articles have appeared in Hudson Valley Magazine, Town and Country Travel, and County Kids.

Prevalence of Tooth Decay in Children

Age	1985-1994	1999-2004
2-5*	24%	28%
6-11*	50%	51%
12-15°	57%	51%
16-19°	78%	67%

* decay in primary (baby) teeth

° decay in secondary (adult) teeth

Centers for Disease Control and Prevention



Perspectives on Parenting

By Michael K. Meyerhoff, EdD

The Importance of Co-Regulation

There is a critically important concept in childrearing referred to as “co-regulation.” It is defined as “a transitional stage in the control of behavior in which parents exercise general supervision and children exercise moment-to-moment self-regulation.” And it is most commonly associated with the period of middle childhood, otherwise known as the elementary school years.

Let’s take the example of a between-meal snack. A preschooler gets hungry between lunch and dinner and asks if he can have something to eat. You wouldn’t say, “Go get yourself whatever you want.” You decide whether or not it is appropriate for him to have a snack. You decide what he will eat and how much. And you watch over him carefully as he consumes it. On the other hand, an adolescent won’t even bother to ask you. He simply will go into the kitchen and raid the refrigerator according to his own particular preferences.

The elementary school child presents an entirely different case. In all likelihood, he will be inclined to ask for permission rather than pursue completely independent indulgence. However, at this point in your child’s development, your response might be something like, “Okay, you can have a snack. But try to eat something healthy, and don’t eat too much because we’re going to have dinner in a couple of hours.” Then it would be up to him to decide precisely what the snack will be and exactly how much of it he will consume.

Co-regulation used to be a standard phase in the parenting process. Unfortunately, in recent years, while not necessarily rare, it is becoming far less routine. It seems as if many mothers and fathers are continuing to micro-manage their children’s behavior well past the preschool years – sometimes well into late adolescence. This is extremely problematical because someday their children will be beyond their physical control. And if the children have not had ample opportunities to attempt, practice, and perfect decision making on their own, they will not have developed skills that will be crucial for survival and success out in the world.

Believe it or not, the following is a true story. I know

a very bright young man who got accepted to a rather prestigious college. When his parents sent him off to pursue his studies a couple of hundred miles away, they set up a checking account for him. They made it a joint checking account so they could deposit additional funds as needed.

Their son was away for barely three weeks when they received a notice from the bank stating that checks were being returned for insufficient funds. Given that they had initially deposited a rather large amount of money in the account, they were surprised and puzzled. Seeking an explanation, they called their son and informed him that the checking account was overdrawn. “That’s impossible!” he replied with equal surprise and puzzlement. “I still have checks left!”

As incredible as this tale may be, I have to say that similar stories are becoming increasingly common. Every semester, I teach an introductory psychology class at the local community college. And each spring, an ever-larger portion of my students are kids who went away to college in the fall but had to drop out and return home because they got into serious trouble by drinking, partying, and otherwise failing to manage their behavior to the point where their studies were almost totally neglected. I also am seeing more and more students withdrawing from school because their inability to control their credit card and cell phone bills has resulted in their inability to make their tuition payments. In most cases, it is clear that these kids are not stupid. They simply have never had the chance to learn how to make good decisions on their own.

I can understand that many mothers and fathers are reluctant to let their young children manage their own behavior, even to a limited extent. After all, little ones can get hurt and can get into trouble. Allowing them to go play by themselves or permitting them to set their own homework routines, even within general parameters set by the parents, can result in injuries and poor grades.

But that is why pursuing co-regulation during middle childhood is so important. The fact is that making mistakes is an integral part of the educational process.

However, at this point in development, the kind of mistakes that kids may make will not have tremendously dire consequences. They may get hurt and they may fail, and they may certainly suffer as a result. But the damage is not likely to be permanent, and the discomfort will teach them to pay attention, be careful, and avoid making the same type of mistakes in the future.

A good analogy would be protecting your offspring from physical injury. When kids start riding bikes and racing around on their rollerblades, many mothers and fathers dress them up in helmets, knee pads, elbow guards, and other pieces of protective equipment until their little ones look like knights in full armor. Consequently, it is virtually impossible for them to get hurt. No concussions, no skinned knees, and no bruised elbows. Unfortunately, this emboldens the children into taking bigger and bigger chances and engaging in ever increasingly reckless behavior. As a result, the first time they do get injured is when they break their necks flying off the roof of the house or pursuing some other extreme stunt.

Now it may be wise to provide a helmet as even a small blow to the head can cause major problems. But it may also be wise to do without the knee pads and elbow guards. Those skinned knees and bruised elbows will be painful, but they won't be fatal. And the pain will definitely encourage the kids to be more sensible in their subsequent recreational pursuits.

So the next time your elementary school-aged child is bored, set up a reasonably safe environment and supply him with a collection of suitable materials. But don't tell him what to play and how to play. The next time he has a homework assignment, make sure he has ample time and sufficient resources. But don't tell him what he has to do and how to do it. Give him an allowance and set some limits on what he can purchase, but don't tell him in great detail how he can spend his money.

As your child makes his choices, and even if he appears headed for trouble, let yourself cringe, but resist the urge to step in too quickly. Whatever minor calamities you and he endure as he experiences the consequences of making poor choices will pale in comparison to the major catastrophes that will occur in the future if he never learns to make good decisions for himself.

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Missed Opportunities From Misdiagnosis

By Vikki Sloviter

Parents of teens may not want to know, but the urinary complaints that their child may present to a doctor may not be a urinary tract infection (UTI) but a sexually transmitted infection (STI). In a study published in the *Journal of Adolescent Health* earlier this year, Dr. Najah S. Musacchio of Children's Memorial Hospital in Chicago, IL, and her colleagues found that 55% of the adolescents that presented to one Toronto hospital's emergency department with urinary complaints were not asked if they were sexually active, thereby presenting a "missed opportunity" for diagnosis and treatment of sexually transmitted infection.

The study looked at the medical charts of 163 adolescents who had gone to the emergency department with various symptoms indicative of urinary tract infection, but also sexually transmitted infection. The patients had symptoms that included painful or frequent urination, abdominal pain, blood in the urine, back pain, urge to urinate, genital discharge, fever or vomiting. Even though several guidelines indicate that adolescents that complain of urinary symptoms should be asked if they are sexually active, 49 of the study's patients had not been asked that question. Of the 114 patients who had been asked about sexual activity, 84 were sexually active. Yet, only half of those who affirmed they were sexually active were tested for sexually transmitted infection.

It's no surprise why many young adult patients aren't asked about their sexual activity: their parents are with them. Though there are other reasons that adolescents aren't often checked for STIs – including not enough time and insurance coverage issues – the fact that mom or dad is usually in the exam room with their child creates an awkward and potentially embarrassing situation. Under such stress, an adolescent may not admit to being sexually active and inadvertently be misdiagnosed and mistreated. Dr. Musacchio always asks the parent to leave the room when she talks with a young adult patient who may be sexually active.

Adolescents are people, too. And, much to some parents' dismay and disbelief, some of them are even sexually active. If you haven't already had a frank talk about sex with your adolescent, do so. But more importantly, make sure your young teen is treated for what she really has, whether it's a urinary infection or a sexually transmitted one.

Infant Snoring, Mental Development, and Cigarette Smoke Exposure

By Hawley Montgomery-Downs, PhD

Obstructive sleep apnea is a sleep disorder signified by episodes when the patient is unable to breathe during sleep and must wake up for a few seconds to resume breathing before returning to sleep. These episodes can happen frequently throughout the night and the most pronounced symptom of the disorder or of “sleep-disordered breathing” in both adults and children is snoring.

Adults with this disorder have been studied for many years, and in addition to serious cardiovascular consequences, it has been discovered that impaired mood, cognitive performance and motor function are caused by this sleep disorder. Researchers who study preschool and school-age children have also clearly established a link between sleep-disordered breathing and children’s behavior, learning, and memory functioning.

Isolated studies of children have examined the effects of snoring alone when it results in disturbed sleep but does not indicate sleep-disordered breathing. The investigators in these studies have found that among older children, learning is impaired simply by the presence of snoring even in the absence of a diagnosable sleep disorder. This means that snoring doesn’t just indicate that a child may have sleep-disordered breathing, snoring itself may be a problem if it interferes with sleep by causing very brief, repeated awakenings throughout the night called “arousals.” Such arousals are so short that the child doesn’t remember them and an adult watching or sleeping next to the child may not realize they’re happening.

With this information in mind, our goal was to look at whether snoring had any effect on development or performance among young infants. The results of this National Institutes of Health-funded study were published in the medical journal *Pediatrics* under the title “Snore-Associated Sleep Fragmentation in Infancy: Mental Development Effects and Contribution of Secondhand Cigarette Smoke Exposure.”

We conducted the study in Louisville, KY, where parents whose infants were born at local hospitals were asked to fill out surveys about their infant’s sleeping and snoring, as well as information about themselves including whether or not they smoked. When they were eight months old, 35 infants took part in the study.

These infants were brought to the sleep research center by their parents and each had small sensors placed on their scalps, faces and chests to measure their brain activity, eye movements, and heart patterns; stretchy bands around their chests and abdomens measured their breathing patterns and a small sensor in front of their noses measured their breathing. A final sensor on their necks measured the vibrations of snoring. None of these sensors hurt the children, although the parents and sleep center technician had to be creative to prevent the children from removing them. The infants’ mothers spent the night in the same room with their infants so that they would be close by if their infants awoke during the night, and could feed or comfort their infants following their normal routine.

The next morning, a researcher administered a play test called the Bayley Scales of Infant Development, which measures infants’ mental and motor abilities as well as their behavior. This test tells us whether an individual infant is performing at, above, or below the range expected for their age group.

What we found was that none of the infants in the study had sleep-disordered breathing. None of them had a single period during the night when they stopped breathing. However, most of them did have times during the night when they snored. Some of the infants had snoring that caused arousals and some did not.

Although all of the infants were within the normal range on the mental development test, we found a negative relationship between the number of times per hour that the snore-related arousals occurred, and the infant’s score on the mental development index. This means that the more times each hour that an infant had snore-related arousals, the lower, or worse, their score was on the mental development scale.

Further, it was determined that while living in a smoking household did not increase the chances that an infant would snore, it did increase the risk of that snoring causing arousals. Among the infants who snored, but did not have arousals, 50% lived in a household where either parent smoked. Among those whose snoring caused arousals, 100% lived in a smoking household.

The data from this study indicate that exposure to cigarette smoke may increase the deleterious effects of infant snoring by causing frequent interruptions to normal sleep. When placed in the context of previous research, one concern is that the infants whose snoring caused arousals may go on to develop diagnosable sleep-disordered breathing.

Hawley Montgomery-Downs, PhD is an Assistant Professor of Psychology and an Adjunct Assistant Professor of Pediatrics at West Virginia University. Research in her Sleep and Sleep Disorders Laboratory focuses on developmental aspects of pediatric sleep and sleep-disordered breathing.

Ten Things You Need to Know About Food Allergy

By Scott H. Sicherer, MD

Understanding your child's food allergy is the first step toward effectively managing it and providing a safe, happy and healthful environment. Here, I pose and answer ten questions I am frequently asked by parents whose child may have, or has been diagnosed with, a food allergy.

How Do I Know If My Child Has a Food Allergy?

Food allergy occurs when the immune system, the part of the body that is designed to fight infections, mistakenly attacks protein in foods. One way this happens is when the immune system makes a protein called "IgE" that can detect a specific food protein and alert allergy cells to release chemicals that cause symptoms. The most typical symptoms involve the skin with hives that look like mosquito bites. Lips and eyelids may become swollen. These symptoms usually begin within minutes of eating the food. Additional symptoms of a sudden food-allergic reaction are gut symptoms (vomiting, pain) and breathing problems (coughing, wheezing-like asthma, throat tightness or trouble breathing). A severe reaction is called anaphylaxis and may include trouble breathing and poor blood circulation (poor pulse, paleness or blueness, passing out). An allergic reaction leading to anaphylaxis does not necessarily include skin symptoms.

When these typical symptoms occur soon after a food was ingested, it is likely that your child has experienced a food-allergic reaction. However, food allergy can also contribute to chronic illnesses. For example, about one in three children with an itchy skin rash called atopic dermatitis (eczema) has food allergy. Food allergy can also contribute to gut problems such as chronic vomiting, diarrhea and poor growth. Though there are many potential reasons for these chronic skin or gut symptoms, such as infections, food allergy is one trigger to consider.

Sometimes, illness can occur from foods but not because of an allergy. For example, an inability to digest the sugar in milk, called lactose intolerance, can result in stomach upset and loose stools; a child may be sleepless because of caffeine in foods causing a pharmacologic response; or, a child may have vomiting and diarrhea from eating spoiled food (a toxic reaction). These three examples of adverse food reactions are not allergies.

What Kinds of Tests Are Done to Know If My Child Has a Food Allergy?

Your doctor will ask you questions about symptoms and their relationship to foods. This give and take of a medical history is by far the most important "test" for a food allergy. Your doctor will determine if the symptoms are ones typical of a food allergy, and which foods may be problematic. If your child's doctor suspects a food allergy, then she can do a blood test to see if your child's body made IgE to the food(s) under suspicion. The test is not perfect because sometimes an allergy to a food exists even though the test is negative, and sometimes the test is positive in people who tolerate eating the food, or who outgrew an allergy. Therefore, the test has to be interpreted by your doctor, who takes many factors into consideration. One factor is the degree to which the test is positive because the more positive, the more likely there is an actual allergy.

An allergist is a specialist who has additional training to diagnose and manage a food allergy. Allergists may additionally perform allergy skin tests, called prick or scratch tests, where a diluted extract of the food is scratched on the skin surface, a relatively painless procedure. An itchy bump indicates your child has IgE that detects the food, and like the blood test, the degree of response reflects the likelihood of a true allergy. Both the skin and blood tests measure the same thing, but sometimes one test or the other is better at

detecting IgE (usually the skin test) depending on various circumstances.

Some types of food allergies happen without IgE and your allergist may conduct periods of food elimination and feeding under doctor supervision (called an oral food challenge) to diagnose these. In the end, your doctor can confirm a diagnosis by using a combination of the medical history, test results, and possibly the results of an oral food challenge. In children, milk, egg, peanut, tree nuts, (e.g., walnut, cashew, Brazil nut, etc), wheat, soy and seafood (fish and shellfish) are the most common foods to cause allergies.

How Do I Know If My Child's Food Allergy Is Severe?

There is currently no test that determines how severe an allergy may be. It is not necessarily true that a higher test result indicates a more severe allergy. There are certain foods that are more common to cause severe reactions: peanuts, tree nuts and seafood. However, severe reactions (anaphylaxis) can be caused by milk, egg, wheat and almost any other food. Various studies indicate that people with asthma are at higher risk for food anaphylaxis, as are people who have had reactions to trace amounts of food. Teenagers and young adults seem to be at highest risk for fatal anaphylaxis, probably because they are more prone to eat without caution and not treat an allergic reaction promptly (either because they did not have available, or delayed using, medications).

How Do I Treat a Severe Allergic Reaction?

Epinephrine (adrenaline) is an injected prescription medication that relieves the most dangerous symptoms of a severe allergic reaction. It opens clogged breathing tubes, reduces swelling, and, most importantly, makes the heart and blood vessels more effectively circulate blood. It should be injected promptly in the event of a severe reaction. It is available as an auto-injector that is easy to use, though a supervising adult would typically administer it.

If your child experienced anaphylaxis, or is at increased risk, your child's doctor or allergist should prescribe this medication to be carried at all times. It is important to review with your allergist or doctor when and how to inject the medicine. Sometimes parents worry that they may be injecting it when it was not really needed, but it is a very safe treatment with few minor side effects and so when in doubt, it is usually better to inject.

In the event of a severe reaction, it is important to get to advanced care, such as an emergency room, usually by dialing 911. Sometimes an allergic reaction subsides

but recurs within a few hours so at least four hours in the emergency room after symptoms fade is recommended. Additional treatments include antihistamines, asthma medications, and steroids but these cannot be depended upon in anaphylaxis. Your doctor should also prescribe a written treatment plan for anaphylaxis.

Will My Child Be Allergic to Related Foods?

It depends on the food. Peanut is a bean but over 90% of people with peanut allergy tolerate other beans. On the other hand, most people with tree nut, fish or shellfish allergy react to multiple types. People with cow's milk allergy usually (>90%) react also to goat's milk. Your allergist can provide advice about the possibility of allergy to related foods. The most important point to remember is that if your child tolerates a particular food without any sign of illness, then that food is not a food allergen for your child (even if a test is positive).

How Much Food Could Cause an Allergic Reaction?

It is a misconception that food allergy is defined by reactions to trace amounts of the food. In fact, for many people with food allergy, a reaction may not arise until modest amounts are eaten (a few peanuts or more, an ounce of milk or more, etc.). However, some people are sensitive to trace amounts. Some types of food allergies are mild, such as having an itchy tongue from raw apples (though some people are more sensitive). Unfortunately, there are no simple tests to determine how sensitive your child may be, and so caution is typically advised to strictly avoid most food allergens.

Will Touching or Smelling a Food Cause an Allergic Reaction?

When an allergist performs an allergy skin test with a food, he is essentially doing an exaggerated touch test; it is extremely rare (less than 1 in 10,000) for the test to cause a significant allergic reaction beyond the point of touch.

Most foods do not get airborne easily, but there are circumstances when they may: cooking eggs, boiling milk, frying fish, a fish market, preparing flour, etc. In contrast, peanut butter does not seem to emit airborne peanut protein. Studies on these air exposures typically show they can trigger reactions similar to those that happen when, for example, a person with cat allergy is around cats (itchy eyes and nose, coughing and possibly wheezing).

The main concern about casual exposure is to avoid ingesting the food by transfer of food from objects or saliva into the mouth, which is a concern especially for infants and young children. Pitfalls include: passion-

ate kissing, sharing a drink, infants/toddlers sucking on toys, etc. Therefore, careful supervision of toddlers and reminding caregivers and older children about not sharing food is important.

How Do I Provide a Safe Environment For My Child and Have Safe Meals at School, in Restaurants or While Traveling?

Education. You, your child (age-appropriate) and caretakers must understand how to avoid cross contact in meal preparation (e.g., a serving utensil could be contaminated). They must know how to read ingredients labels on commercial products (labeling laws are improving the difficulties encountered because certain, but not all, food allergens must now be disclosed). They must understand how to communicate with restaurant personnel to obtain a safe meal. They must know how to present substitutions that allow your child to participate in appropriate activities (attend parties, restaurants, celebrations, crafts, etc). Your child and her caregivers must be familiar with the signs of an allergic reaction and know what to do for treatment. An increasing number of resources are available for this education (e.g., books, www.foodallergy.org). The goal must be to have your child participate in activities just like his peers, except for eating the food to which he is allergic.

Will the Food Allergy Go Away?

About 85% of children lose their allergies to egg, milk, wheat and soy by age five years. One in five young children will outgrow a peanut allergy. Allergies to seafood and nuts are more persistent. Your allergist can monitor allergies over time to watch for resolution.

Is There a Way to Prevent or Cure Food Allergies?

In regard to prevention, the best evidence for a newborn that may be allergy prone is to exclusively breastfeed for at least four to six months and avoid the use of standard infant formula such as cow's milk or soy formula. If a formula is needed, studies show that use of extensive, or perhaps, partial hydrolysates may help to prevent or delay milk allergy and atopic dermatitis. You should ask your doctor or allergist about these.

There have been additional recommendations such as having the mother avoid certain foods in her diet or to avoid giving a child allergenic foods until he is much older, but these suggestions are not well validated. Once a child has any sign of allergy, "prevention" turns to treatment with trying to identify causal foods.

In regard to a cure, there is currently no simple way to make the allergies disappear. However, researchers are looking at numerous ways, such as allergy "shots," special ways to slowly feed the foods to get the immune system to accept them, and even Chinese herbal remedies, to reverse allergies or make reactions less severe.

Scott H. Sicherer, MD, author of a new book, Understanding and Managing Your Child's Food Allergies, is an associate professor of pediatrics at the Mount Sinai School of Medicine and a researcher in the Jaffe Food Allergy Institute at Mount Sinai. He is an associate editor of the Journal of Allergy and Clinical Immunology, medical advisor for the Food Allergy & Anaphylaxis Network and the Food Allergy Initiative, and author of over 100 articles, research papers, reviews, books and book chapters on food allergy.

Quick Shots

Doctors and nurses are always looking for ways to make shots less painful. A group of doctors in Canada found a way – give the shot quickly.

The doctors compared the pain reaction of 113 infants who received immunizations. One-half were given the shots using "standard care" injection technique and the other half with what the authors call a "pragmatic" approach.

The standard care approach is the way most shots are given – slow aspiration prior to injection (slowly pulling back on the syringe's plunger to make sure the needle is not in a blood vessel), slow injection of the vaccine,

and slow removal of the needle from the child's skin. With the pragmatic approach, there is no aspiration, the vaccine is injected rapidly, and the needle is quickly withdrawn from the skin.

The infants that received the vaccine with the pragmatic approach registered half as much pain as those given the vaccine with the standard care approach. There were no adverse effects from the immunization in either group. The doctors recommend that all vaccinations be given using the pragmatic approach.

Archives of Disease in Children, 12/07

Your Questions Answered

Alvin Eden, MD and Roy Benaroch, MD, answer your questions this month. Dr. Eden practices in Forest Hills, NY. Dr. Benaroch's practice is in Atlanta, GA. Dr. Eden's new book, *Positive Parenting*, is now available.

Send your questions to QandA@pedsforparents.com or Pediatrics for Parents, PO Box 219, Gloucester, MA 01931. Please keep them general in nature as we can't give specific advice nor suggest treatment for your child. All such questions should be asked of your child's doctor.

Rotavirus Vaccine

Q Should my child get the new rotavirus vaccine?

A Rotavirus can cause severe diarrhea, often accompanied by fever and vomiting. It affects the youngest babies the most severely, but can infect adult caregivers as well. In my office, every winter I see dozens of miserable families where both the children and adults have caught this nasty virus.

The infection can be quite serious, and accounts for about 50,000 hospitalizations and 50 deaths each year in the United States. Worldwide, rotavirus is devastating and causes approximately 600,000 child deaths among children.

Unfortunately, rotavirus is very contagious. People can spread rotavirus even before they realize they're sick, and a tiny amount of contamination is enough to infect multiple people. In a daycare centers with small babies in diapers, rotavirus inevitably spreads throughout the children and staff once an outbreak begins.

Two new rotavirus vaccines have been recently developed. The first, Rotateq, became available in 2006. A second brand, Rotarix, will be available soon. Both work similarly and are very effective in preventing the rotavirus infection. Most children who receive the vaccine will be completely protected from infection for at least a few years.

If a vaccinated child does become infected, the disease will be milder. The rotavirus vaccines are given as an oral liquid at two, four, and six months of age. It cannot be given to older children as a "catch-up."

I recommend highly that babies in my practice receive this important vaccine. It will help keep the babies healthier, and help protect their families from the spread of rotavirus as well. The vaccine has been extensively studied and is very safe, with a minimal number of minor side effects reported. If you have a child less

than two months old, talk with your child's physician about getting the rotavirus vaccine for your baby.

Roy Benaroch, MD

Obese Babies

Q My one-year-old girl only weighs 16 pounds. She was five pounds at birth. She is an active happy baby. Is she too thin?

A Based on her birth weight, the answer is that she is not too thin but just about right. Let me give you some statistics. On average, a baby will double his or her birth weight by five months of age. And, on average, a baby will triple the birth weight by 12 months of age. So that at one year your baby should weigh about 15 pounds. Since your baby weighs 16 pounds, you need not worry about your baby's weight. On the other hand, a baby that weighs eight pounds at birth should weigh about 24 pounds at his first birthday party.

In my experience, many parents are too concerned about how much weight their babies gain each month. And their concern can result in overfeeding, which is never advisable. When your baby no longer is interested in the milk or solid food it's being offered during a meal, the meal should stop, rather than when you think your baby has had enough. The title of the first book I wrote, *Growing Up Thin*, should give you a good idea of where I stand on the subject. We are now dealing with an epidemic of childhood obesity, and one of the causes is early childhood overfeeding.

While on the subject of childhood obesity, I would like to emphasize that your baby's toddler years (one to three years of age) are most important as far as preventing obesity. One preventive strategy that works is to cut down on the amount of juice she drinks to a maximum of four ounces each day. Another is to restrict the so-called "junk food" snacks and substitute raw fruit instead. And finally, encourage your toddler to exercise rather than sit around and watch TV. The American Academy of Pediatrics recommends no TV for the first two years of life, and I agree.

Alvin Eden, MD

Discipline and Disability: Determining When a Child's Misbehavior in School is Related to a Disability

By Randy Chapman

As a parent, Maria had a long rope but she was quickly nearing the end of it. The principal or her son's school had just called and asked her to come to school to pick up her son Jeremy, because Jeremy's teacher said he was "out of control." Jeremy hadn't finished his work during class time and when the teacher told him he had to stay in during recess he had thrown his book at the chalkboard. Maria knew Jeremy could sometimes be a handful. He was in special education and had some emotional/behavioral issues, but this was the fourth time this fall that she'd been called and Jeremy had now missed ten days of school. This time the principal said he was suspended for another ten days and might be expelled or moved to a different school because his behavior was so disruptive.

While Maria knew that Jeremy's behavior was not acceptable, she believed it was related to his disability, and that there might be better ways to deal with it than withholding recess. Jeremy struggled to sit still through class and recess was a much-needed break. It didn't seem fair that he might be expelled for "misbehavior" that was not Jeremy's fault. Hadn't she heard that students with disabilities could not be punished for behavior that was a manifestation of their disability? Didn't the law require that, as a child with a disability, Jeremy was entitled to appropriate educational services?

The Individuals with Disabilities Education Act (IDEA) provides that all children with disabilities have a right to a free appropriate public education, including children who are suspended or expelled. The IDEA has specific procedures for school administrators to follow when disciplining children with disabilities. These procedures balance the need to keep schools safe with the right of children with disabilities to receive a free appropriate public education.

There is a process to determine if a student's misconduct is a manifestation of the student's disability, and prevents children from being punished for "misbehavior" that is related to the child's disability. Unfortunately, the IDEA's procedures can be confusing. Here are some questions and answers regarding the manifestation determination process that should make the process clearer.

Who makes the manifestation determination?

The manifestation determination is made by a group that includes the child's parent and the relevant members of the child's Individualized Educational Program (IEP) team. The parent and school administrators decide which IEP team members will be included in the meeting.

When must a manifestation determination be made?

Whenever the school decides to remove or suspend a student with a disability from the student's educational placement for more than 10 school days.

How does the group decide if the student's misconduct is a manifestation of the student's disability?

First, the group will review all of the relevant information in the student's file including any information from the IEP, teacher observations, and information provided by the student's parents. Based on that review, the group will determine whether:

1. The student's misconduct was caused by, or was directly or substantially related to, the student's disability; or
2. The misconduct was the direct result of the school district not implementing the student's IEP.

If the group determines that the misconduct was related to the student's disability or was the direct result of the IEP not being implemented, then the team will determine that the misconduct was a manifestation of the student's disability.

If the student knows right from wrong and understands it is wrong to violate the student code of conduct, doesn't that mean his misconduct was not a manifestation of their disability?

No, the student may know his behavior is wrong but the misconduct might still be directly related to his disability. For example, the student's disability may limit his ability to control the behavior. Or, perhaps IEP services, such as counseling, were never provided, causing the student's behavior to escalate beyond the student's control.

What happens if the student's misconduct is determined to be a manifestation of the student's disability?

The student's IEP team will meet and, unless there are special circumstances or the IEP team changes the student's educational placement, the student will return to the school program he were in before the suspension. The IEP team will also conduct a Functional Behavioral Assessment and will implement a behavior intervention plan for the student. A Functional Behavior Assessment gathers information about the student's behavior to determine what function the student's behavior serves for the student. The behavior intervention plan is the plan to provide support to the student to intervene with the behavior.

What are special circumstances?

In disciplinary situations involving possession of weapons, illegal drugs, or serious injury, the school may remove the student for up to 45 school days, even if the misconduct is a manifestation of the student's disability. The student must receive appropriate educational services after the first 10 school days that the student is removed.

What if the group determines that the misconduct is NOT a manifestation of the student's disability?

If the student's misconduct is not a manifestation of his disability then he may be disciplined the same

as a student without a disability. But if expelled, the student is still entitled to receive a free appropriate public education. In many cases the student's behavior is determined to be a manifestation of the student's disability. But, parents have the right to appeal a decision that their child's behavior is not related to their child's disability. Hearings to resolve disagreements in the disciplinary process are expedited. That means the hearing must be held within 20 school days after it is requested and the decision must be made within 10 school days after the hearing is completed.

As much as an educational and exciting time school is for children, it can be a tough period for children with disabilities. Behavioral and emotional misbehavior in these children can be confused for traditional childhood mischief. Being aware and making sure your child's school is aware of the discipline procedures under the IDEA will ensure your child's success and happiness in his education.

Randy Chapman, the Director of Legal Services at The Legal Center for People with Disabilities and Older People, Colorado's Protection and Advocacy System, has, for 29 years, been promoting and protecting the rights of people with disabilities. He is the author of three books, including The Everyday Guide to Special Education Law. He can be reached at www.thelegalcenter.org.

Adoption Options: Selecting the Right Agency to Build Your Family

By Kim Hahn

Choosing to adopt a child is a momentous decision, but it's only the first of many that you'll have to make as your adoption moves forward. The next big choice is whether to adopt domestically or internationally. While international adoptions more often make the news, domestic adoptions are vastly more common.

If you decide to adopt domestically, you'll need to hire an agency to guide you through the process. You'll be trusting this agency to help you bring home a new son or daughter, so be sure to choose one that will accomplish this task quickly, efficiently, sensitively, and ethically.

Adoption is a very personal journey and it's important to choose an agency you're comfortable with to assist you down that path. Here are some questions to help you narrow your search:

Can we continue pursuing fertility treatments?

Some agencies will specifically state you are not to undergo fertility treatments during the process of adoption. Other agencies don't have this requirement.

Can we specify our preference for a boy or girl?

There are agencies that will allow you to wait for a specific gender, while others don't permit you to specify.

What is the ratio of adoptive parents to birth mothers?

This ratio will help you estimate how quickly you'll be selected by or placed with a birth mother and child. For example, if there are 100 prospective adoptive couples to 50 birth mothers registered with the agency, you have a 50% chance of being able to adopt quickly.

How does the agency locate birth mothers?

Ask whether birth moms contact the agency, or whether the agency has a marketing program to attract birth mothers.

What is the average wait time from application approval to placement?

Agencies vary on how long the average wait time for parents is, and couples vary on how long a wait is acceptable. Make sure you choose an agency whose stated wait time is within your comfort zone.

What kind of support do you offer adoptive parents and birth mothers?

The needs of adoptive parents and birth mothers are very different. Look for an agency that has separate personnel with specific training to provide support for all parties involved in an adoption.

Does the birth mother select parents or are children placed by the agency?

The process is very different in each case. If you're going to be selected by the birth mom, you have to put together marketing materials – letters and photos about yourself and your family. In this case, your wait is indeterminate, depending on how well you've presented yourself as prospective parents. If children are placed by the agency, the process is more like getting in line – you'll be matched with a baby when it's your turn. Most domestic agencies now lean towards letting the birth mothers choose.

What criteria does the agency use to match birth mothers with adoptive parents?

When you sign with most agencies, you'll be given a checklist to indicate what you find acceptable. The birth mother also receives a checklist. You may decide, for instance, that you aren't willing to adopt from a birth mother who is addicted to drugs, but you don't mind if she drank coffee or caffeinated sodas throughout pregnancy. The birth mother might not want her child raised by a single parent, or may prefer a family that already has children at home. The agency uses these checklists to help make a match.

Does the agency charge one set price or are the fees "a la carte?"

Agencies that charge a fixed price generally charge a higher fee, but you'll know up front what your costs will be. The fee will cover the entire process, including another match if one birth mom changes her mind before the adoption. But if you're working with an agency that charges per service and the birth mom changes her mind, you'll have to pay to start over again. You can save money by paying per service if everything goes smoothly, but it's a bit of a gamble.

Can you handle open, closed or semi-closed adoptions?

This is a matter of agency policy, and determines whether or not you'll be obligated to communicate with the birth mother after the adoption is final. In a closed adoption, birth and adoptive parents do not know each other, and their identities are protected. Semi-open adoptions allow the birth mom and adoptive family to exchange letters, usually through the adoption agency so that names and addresses can be concealed. Open adoption means that birth moms and adoptive families know each other's names and addresses, and can make an agreement to stay in touch, frequently or infrequently, as the child grows up. You have to decide what your level of comfort is, and then find an agency to support it.

What protective and proactive steps are taken to ensure the birth parents' rights are terminated?

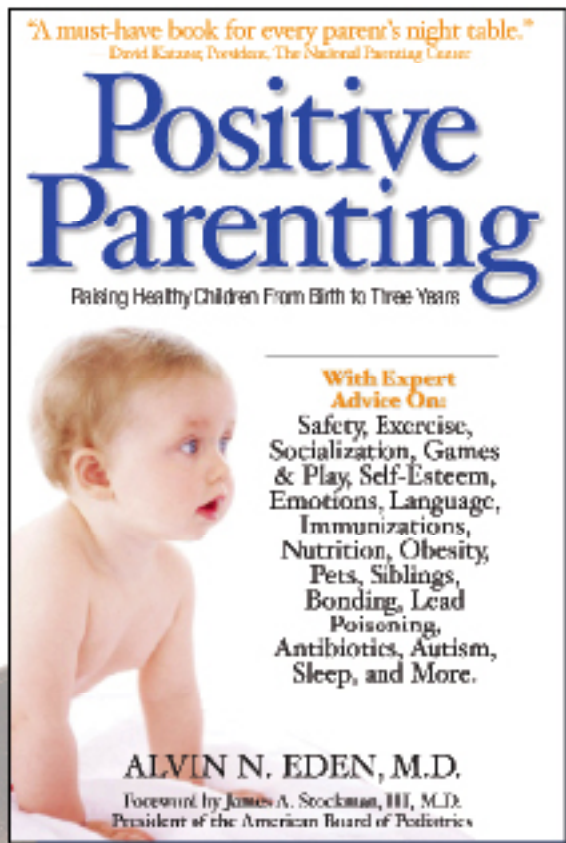
For obvious reasons you want to make sure that your agency doesn't cut any corners, and takes every legal step to make sure the adoption won't be challenged. Ask about the agency's success record. You want to make sure that the agency has never had a child removed from a home after being placed for adoption because of loopholes that allowed a birth parent to reclaim the child. You should also check your home state's laws, since not all fifty states treat adoption equally. The rights of the birth father, for instance, vary widely among states. Obviously all adoptive parents want to avoid the heartbreaking scenario of bringing a child home and growing deeply attached, only to have a birth parent come back to challenge the adoption. If your state's laws make you uncomfortable, you can choose to adopt in another state.

Although the process of adoption can seem overwhelming, doing your homework and asking all the right questions will help you bring home the child you've been dreaming of. And when your son or daughter joins your family, you'll realize that all the time and effort was well spent. Knowledge and preparation about adoption options are the best way to ensure a happy and successful outcome.

Kim Hahn is the founder and CEO of Intellectual Capital Productions, Inc., a multimedia company featuring Conceive Magazine and the online radio show, Conceive On-Air. She is a highly sought after speaker and author, helping others to overcome obstacles to find success in life and business. Kim serves on advisory boards for the International Council for Infertility Information Dissemination (INCIID), the Centers for Disease Control and Prevention, the March of Dimes and the University of Florida. For more information, please contact Kim at (407) 447-2456 or at kim@conceivemagazine.com.

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Tips to Help Young Spenders Be Good Investors

By J.M. Seymour

Many American teens have aspirations to be famous NBA players, wealthy rock stars, or the next Donald Trump. Yet these same teens let plenty of riches slip through their hands today, without realizing the irony that they are already spending a small fortune – about \$100 a week. That's more pocket change than any other generation of teens, according to surveys by Teenage Research Unlimited.

Because they are busy learning to spend, rather than save and invest, teenagers are not honing their financial skills either. The result? Skyrocketing credit card debt, dwindling savings, more personal bankruptcies, lost opportunities for wealth, and young consumers who make easy targets for con artists and scams.

Part of the issue is many parents do not teach their kids much about money management, but expect them to absorb basic financial skills and learn the rest in the classroom. Yet teens, even the academically talented, aren't getting it at school either. A survey conducted last year by the national Jump\$tart Coalition for Personal Financial Literacy, reveals that most high school seniors failed a basic personal finance test.

Recognizing the importance of good money management, more states are requiring high school students to pass a course in personal finance before graduating. Still, high school may be too late. Middle school and late elementary years are really the most formative time to impact money habits, particularly for young spenders with a penchant for investing.

Here are four ways to start children on the investing path and toward a rosier financial future:

Walk the Talk

Kids still learn to spend, save, and invest by modeling behavior, particularly habits of those around them. So, show that managing money to create wealth is much more than a skill – it's a lifestyle. Include kids in discussions about family finances – let them hear how major purchases are made, where vacation money comes from, and how much college costs. Discuss how choices today impact financial abilities downstream. (Example: Is it wiser to take large loans to get a B.S. at an expensive private college or to attend a public university that costs less?) Together, choose several colleges or universities, and calculate tuition, room/board, books, and other fees per year. Select a couple of career choices and research starting salaries. Dis-

cuss how many years of college are needed, compare income potential of each choice, and calculate years needed to repay loans.

Invest in Learning to Invest

Teach kids not only to save money, but how to use it as a tool to make more money. Astute 10 and 11 year olds can grasp concepts such as how the stock market works. You needn't be an expert to start down the investing path, and you can learn along with the kids. Check for free ideas and materials at www.sec.gov/investor/students/tips.htm, www.treas.gov/kids/index.html, or www.dynamindspublishing.com.

Get Real

There's nothing like using real cash to grab someone's attention. Open a savings or investment account together, so kids have a place to accumulate money to invest. Help them find good investments and use a simple way to keep track of ups and downs. One good habit any investor can start is using an investment journal. And, you might also want to join or start an investment club. Remember, you don't have to know it all before you begin. Spend time together to learn concepts, compare companies, research prices, take field trips, or attend local stockholders' meeting.

Help Kids Practice What They Learn

Saving and investing shouldn't feel like punishment or denial, so set goals and give rewards. Help kids realize that becoming successful investors takes practice, just like learning to swim, play piano, or kick a soccer ball. The earlier you practice good investing habits, the better. But it has to be fun and rewarding so that kids stick with it. For example, you can "discover" a publicly traded company by searching for new products at the mall or online.

Saving and investing doesn't require fancy equipment, uniforms, special shoes, or lots of money. Teaching skills that could help your kids become wealthy is not an expensive proposition... but failing to teach them is. Help them get started today. The road to becoming a millionaire awaits.

J.M. Seymour is an avid investor, financial educator, and author of several books and games, including the Stock Market Pie: Grandma Helps Emily Make A Million and the Find Your Money Personality booklet. Download a free copy of "A Baker's Dozen Ideas to Turn Spenders Into Savers," at www.dynamindspublishing.com.

Helping Your Child Learn to Read

By Raymond J. Huntington

There is probably no more important activity for preparing your child to succeed as a reader than reading aloud together. Fill your story times with a variety of books. Be consistent, be patient, and watch the magic work.

Even after children learn to read by themselves, it's still important for you to read aloud together. By reading stories that are on their interest level, but beyond their reading level, you can stretch young readers' understanding and motivate them to improve their skills.

Advertise the Joy of Reading!

Our goal is to motivate children to want to read so they will practice reading independently and, thus, become fluent readers. That happens when children enjoy reading. We parents can do for reading what fast food chains do for hamburgers...advertise! And we advertise by reading great stories and poems to children.

We can help our children find the tools they need to success in life. Having access to information through the printed word is an absolute necessity. Knowledge is power and books are full of it. But reading is more than just a practical tool. Through books we can enrich our minds; we can also relax and enjoy some precious leisure moments.

With your help, your children can begin a lifelong relationship with the printed word, so they grow into adults who read easily and frequently whether for business, knowledge, or pleasure.

Remember When You Were Very Young

Between the ages of 4 and 7, many children begin to recognize words on a page. In our society this may begin with recognition of a logo for a fast food chain or the brand name of a favorite cereal. But, before long, that special moment when a child holds a book and starts to decide the mystery of written words is likely to occur.

You can help remove part of the mystery without worrying about a lot of theory. Just read the stories and poems and let them work their wonders. There is no better way to prepare your child for that moment when reading starts to "click," even if it's years down the road.

It will help, however, if we open our eyes to some things adult readers tend to take for granted. It's easier to be patient when we remember how much children do not know. Here are a few literacy concepts adults know so well we forget sometimes we had to learn them.

- There's a difference between words and pictures. Point to the print as you read aloud.
- Words on a page have meaning, and that is what we learn to read.
- Words go across the page from left to right. Follow with your finger as you read
- Words on a paper are made up of letters and are separated by a space.
- Each letter has at least two forms: one for capital letters and one for small letters.

Imagine how you would feel if you were trying to interpret a book full of hieroglyphics. That's how young readers feel. But, a little patience – maybe by turning it into a puzzle you can solve together – is certain to build confidence.

Home is Where the Heart Is

It's no secret that activities at home are an important supplement to the classroom, but there's more to it than that. There are things that parents can give children at home that the classrooms cannot give.

Children who are read to grow to love books. Over the years, these children will have good memories to treasure. They remember stories that made them laugh and stories that made them cry. They remember sharing these times with someone they love, and they anticipate with joy the time when they will be able to read for themselves.

By reading aloud together, by being examples, and by doing other activities, parents are in a unique position to help children enjoy reading and see the value of it.

Raymond J. Huntington and Eileen Huntington are co-founders of Huntington Learning Center, which has provided supplemental education services to local communities for 29 years. For more information about Huntington Learning Center, call 1-800 CAN LEARN or visit <http://www.huntingtonlearning.com/>.

Tips for Raising a Terrific Preschooler

By Caron B. Goode, EdD

The preschool years are an exciting time for both children and parents. It is the time when children pass through babyhood and enter childhood. During their third and fourth years, children enjoy a great deal of social, emotional, cognitive, and physical growth. They become stronger and more in control of their bodies, emotions, and environment. It is in this stage that many pieces of the puzzle start to fall into place, and parents begin to catch glimpses of the person their child is becoming.

Emotions

Between the ages of three and four, children experience tremendous emotional growth. It is in this stage that children begin to understand and label feelings. They understand on a basic level what causes certain feelings, and will offer simple help to those in distress. When a playmate cries or becomes angry, a child may offer a hug or share a special toy. It is important that parents recognize and encourage this empathetic behavior. This will help children develop compassion. It will also help them learn to identify emotions in themselves and in others.

For a preschooler, learning to identify emotions is the first step towards learning how to manage them. When a child can correctly label feelings, he is better able to express himself and his needs. Parents can help children develop this valuable skill through play. Mirror games, face cards, and play acting are all great ways to help children identify their emotions. Reading and storytelling can also be very helpful. Describing why a favorite character feels a certain way is fun and lets children practice expressing emotions.

As preschoolers begin to identify their emotions, there is a notable shift in how they handle themselves. Tantrums, while still present especially during times of stress, become fewer and farther between. This makes it a great time to teach them how to soothe and comfort themselves. Instructing children to use touch or a simple phrase can go a long way in helping them manage anxiety and stress. A mother may place her hand on her heart and then on her child's to let him know that this is the place where she is always with him. Then throughout the day when he needs reassuring, all he needs to do is touch that place to feel comforted. The same goes for words. For instance, if he suffers separation anxiety repeating the phrase "Daddy will be

back" will remind him that all is well, and his father will return.

Friendship

Friendships are very important in the preschool years. Once children begin to understand emotions and their connection to other people, they begin to establish friendships. For three- and four-year-olds, friendship begins by showing interest in other children and mimicking them. While these children long for playmates, they are just learning the social skills necessary to friendship.

Social skills are learned through practice. Therefore, it is important that parents arrange regular playtime for their children. If a child does not attend daycare or preschool, make playdates or join a playgroup. At three, children may feel more comfortable having a parent present while they play and often turn to them for help with social skills. By the age of four, children are better at reading their playmates emotions. This allows them to formulate their own solutions, which, in turn, makes them less dependent on parental interference.

Fears

Preschoolers often experience a great many fears. They fear everyday things like dogs, baths, and the dark. Dogs are loud, water magically disappears from the tub, and darkness can be scary. These fears are intensified by the fact that it is hard for this age group to separate fantasy from reality. If a three-year-old has a nightmare, it is difficult for him to understand the concept of dreaming. For him, the dream really happened. As adults, parents know this is not the truth of the situation, but it is very important that they treat the child's fear with respect. When a child suffers with nightmares or night terrors, parents need to be understanding and offer comfort. They should address and acknowledge the child's fear. They should also offer comfort in the form of soothing words and loving touch. Sitting with the child and massaging his temples or stomach until he is able to return to sleep can help alleviate the stress and anxiety of fear. Simply having a parent with him until the fear passes makes a child feel safe and cared for.

Self-Esteem

At this stage, children are beginning to develop a sense of self-esteem. A healthy self-esteem is crucial to fu-

ture success. When a child knows he is loved, he feels worthy, capable, and has high self-esteem. At this age, when children are rapidly developing, esteem may be specific to one area. A child may base his sense of worth in making new friends or learning new skills. It is important that parents help their children celebrate their successes, no matter how small. Encourage children to be independent and try new things, and applaud them each step of the way. When a four year-old dresses himself, instead of pointing out that his clothes don't match, congratulate him for a job well done. When a preschooler plays cooperatively with another child for a short period of time, celebrate. These small steps are big accomplishments for young children, and a parent's praise and love is everything at this age.

*Dr. Caron B. Goode is the founder of the Academy for Coaching Parents International, a training and certification program for parent coaches. In addition to duties with the academy, Goode is the founding editor of the website InspiredParenting.net, and the author of eleven books, the most recent of which is *Help Kids Cope with Stress & Trauma*, which includes several chapters on the use of storytelling strategies. For more information on The Academy for Coaching Parents International or to sign up for academy announcements, visit www.acpi.biz.*

Youth Sports Nutrition Tips

By Paula Schmitt

One of the most common questions parents ask regarding their child's nutrition during sports is "What is the healthiest thing for my child to eat and drink before playing sports?"

With our family of athletes, we have learned that offering high-carbohydrate foods (also called complex carbohydrates) versus high protein and fatty foods two to three hours before a game is very important to maintain the energy needed for them. Some examples of high-carbohydrate foods are pastas, breads and cereal, which are digested quicker than high-protein and fatty foods. Unfortunately, most children, and adults, forget just how important nutrition is to good health and athletic performance.

Fruit is actually an excellent source of complex carbohydrates and fluids and can be eaten one to two hours before a sporting event. My children enjoy raw, dried and canned fruits or fruit juice before we head out to a game.

Fluids are extremely important before, during and after a game and my children have discovered that staying hydrated makes for a better performance. For elementary and middle-school aged children, eight ounces of water before, during and after the sporting event is extremely important, especially if the outdoor temperatures are high. During a game, athletes should be allowed to take fluid breaks when needed

to maintain their best and safest performance, and of course, caffeinated and carbonated beverages are not recommended.

If your child tires easily in practice and appears irritable, and her performance suddenly declines, she may be dehydrated. The following are more signs that your child is dehydrated:

- Dry lips and tongue
- Sunken eyes
- Bright-colored or dark urine, or urine with a strong odor
- Infrequent urination
- Apathy or lack of energy
- Thirst

So pack up those water bottles and sport drinks (and don't forget the fruit) and head out after a healthy meal full of high carbohydrates to enjoy your child's sporting activity.

Oh, and don't forget the sunscreen!

*Paula Schmitt, award-winning author of *Living in a Locker Room: A Mom's Tale of Survival in a Houseful of Boys*, has been published in hundreds of publications. She has appeared on numerous radio talk shows and in print publications such as *American Baby*, *Family Circle*, *Parenting*, *The Chicago Tribune*, and many others. To read more of her columns visit www.paulaschmitt.com. Email her at paula@paulaschmitt.com.*

Talk is Cheap - and Priceless

By Jill Gilkerson, PhD

New research has confirmed earlier studies that show the sheer quantity of words a child hears every day from birth to age three is related to his or her academic success, according to the just-released “Power of Talk” study. In fact, 30,000 words is the target number – the same number heard in 18.5 readings of Dr. Seuss’ *The Cat in the Hat*.

Between birth and age three, a child’s cognitive abilities develop more rapidly than at any other time in life. Language development, as well, progresses quickly during this period, from single words to simple sentences and multi-clause sentences. Several-hundred research studies over the last 50 years document the importance of talking to and interacting with your baby, especially during those first three years. Recent studies have shown that simply talking with your child is more powerful than using flashcards, computer programs, television or DVDs to increase or enhance his vocabulary.

In researching their book, *Meaningful Differences*, noted University of Kansas researchers Drs. Betty Hart and Todd Risley conducted multiyear studies in which they tracked the number of words parents and caregivers spoke to children during the first three years of life. Follow-up studies by Hart and Risley with the same children at age nine showed a very close link between the academic success of a child and the number of words the child’s parents spoke to him by age three.

These findings were recently confirmed and further researched by a team of scientists, including language experts and speech technology engineers, in “The Power of Talk” study, which I helped author. The study examined the relationship between talk and child language development. Some key findings included:

- Parents of advanced children in the 90th to 99th percentile on language assessments spoke substantially more to their children than did parents of children who were not as advanced.
- Most language training for children came from mothers, with mothers accounting for 78% of total talk.
- Mothers talked more to daughters than they did to sons.
- Parents talked more to first-born children than to children who followed later in the birth order.

- Most adult talk between parent and child occurred in the late afternoon and early evening.

Given these results, which are supported by other studies, the question naturally becomes one of how much talking is enough. In Hart and Risley, children who scored the highest in reading and math at age ten heard 33 million words from birth to age three, or an average of about 30,000 words per day.

However, the “Power of Talk” study also showed that most parents overestimate the number of words they speak daily to their children. Knowing this, it can be difficult for parents to ensure they are engaging in enough conversations with their child, which is where a measurement system like LENA comes into play.

LENA, which stands for Language Environment Analysis, records a child’s verbal interactions throughout the day and, using proprietary software, provides information about the quality of the child’s language environment. Parents then use this information to modify and improve their conversational interactions with their children, helping to lay the cornerstone of the foundation for their child’s future success.

Judith K. Montgomery, PhD, CCC-SLP, currently Professor in the Department of Special Education and Literacy at Chapman University, has developed other simple suggestions for increasing speech and language skills of young children. As the author of seven books and over 150 journal articles and presentations in speech-language pathology, Dr. Montgomery has developed guidelines for parents that include speaking to the child face to face, calmly, in a fairly quiet environment; using “self talk” (“I am putting on my jacket,” “I am zipping my jacket”); using “parallel talk” (“You picked up the blue car,” “Now you turned the car”); and reading to the child as often as possible.

Dr. Montgomery also has developed some warning signs to help detect if a child may need extra attention in his or her verbal development. Things to watch for include poor eye contact from the child most of the time; the child doesn’t watch your face when you talk; the child gets anxious when others talk; and the child doesn’t use sounds or words to get his needs met.

Every child will develop at different rates and with varying strengths and weaknesses. However, with re-

search supporting the concept that verbal interaction between children, parents and caregivers has integral importance to the child's later intellectual development, every parent should strive to be that one person we all know who just won't stop talking.

Jill Gilkerson, PhD, is Director of Child Language Research at Infoture, Inc., developers of LENA. She received her doctorate from UCLA's Department of Linguistics, concentrating in language acquisition. She also established and served as director of the UCLA Infant Language Lab.

Infant Swimming & Infections

A German study of 2,191 children found that those who participated in infant swimming programs have more infections by age six years than children who did not swim as infants. According to Dr. Joachim Heinrich, the lead researcher, "In this way, the study shows that allowing babies to swim is possibly not as harmless with regard to infections as has been presumed till now."

The children who participated in infant swim programs had a higher incidence of diarrheal illnesses. Although this study didn't look into the reason, other studies have found increased fecal contamination of swimming pools when infants participate in swim programs.

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